BRUCE LUONG, OD – JESSICA LUONG, OD

1016 E HEBRON PKWY SUITE 150 – CARROLLTON TX 75010 – PHONE 469.480.6150

Name: ______________________________ **D.O.B:**____________________

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY AND INITIAL NEXT TO EACH STATEMENT. THE FOLLOWING IS OUR OFFICE POLICIES.	**INITIAL**
Health Insurance: Please make sure we have your current and up to date insurance information. As a courtesy we will gladly file your claims and accept assignment. Although we may estimate you benefits, **we are not responsible for their accuracy**.	☐
Professional fees are non-refundable. Payment is expected at the time services are rendered, including any non-covered portions of insurance.	☐
Each eyewear is made specific to your needs and glasses are processed to be made within the same business day. Refunds are only available if the lab has not started on your customized order, otherwise changes after an order is processed will be subject to **50% fee of the original price**. Remakes/rechecks due to adaptation must be within **90 days** of original order. Full charge will apply after 90 days.	☐
According to the "Fairness to Contact Lens Consumers Act", all prescriptions for contact lenses need to be re-evaluated to ensure proper fit of the lens and health of the cornea. The fitting is a separate and distinct exam from a comprehensive exam, though both may be conducted at the same visit at the discretion of the optometrist. **There is a separate fee for this exam which will be collected at the time of your visit.**	☐
Contact lens follow-ups will be covered by the initial fit and evaluation fee. All follow-ups must be done within the allotted follow-up period from the initial exam to avoid additional fees. **Any visit beyond the follow-up period will result in an additional $35 reassessment fee.** The follow-up period will vary on the type of fitting performed.	☐
If you are filling a prescription not written by our doctor(s), any issues with the vision must be addressed with the prescribing doctor. We, however, will do our best to make any adjustments necessary to make you as comfortable as we can. Any refraction or rechecks from us will incur a **$30 fee**.	☐
All payments are due at the time services are rendered. You are also responsible for all outstanding balances not covered by insurance. By signing, you consent to paying all outstanding balances.	☐
May we have permission to take pictures of you and your NEW eyewear purchased from us to post on our social media? Your name or medical information will not be mentioned.	☐ Yes ☐ No

I have read and affirmed all the statements above. I have the right to voice any concerns regarding any of the above statements. By signing below, I understand and acknowledge **FRAMED EYECARE PLLC** policies.

______________________________ ____________________

Patient's Signature (guardian, if a minor) Date

DILATION POLICY

The doctor highly recommends this test as part of the comprehensive eye examination. Dilation allows the doctor to fully assess the interior health of the eye with a 360 degree field of view. This procedure is important in diagnosing complications within the eye such as diabetes retinopathy, glaucoma, retinal tears or holes, macular degeneration, and more. Dilation leaves the eyes slightly sensitive to light with blurred vision for a few hours. Distance vision is rarely affected. Any additional questions can be answered by the doctor.

Please check one: _____ **YES**, I consent to dilation. _____ **NO**, I decline dilation.

RETINAL PHOTO CONSENT FORM

<u>"What are retinal photos?"</u> ↓

In addition to your exam and dilation, the doctor also recommends the retina/fundus camera which is a new digital retinal imaging system that now allows us to take photographs of your retina (the back of the eye). This assists the doctor in the early detection of many disorders such as glaucoma, diabetic retinopathy, macular degeneration, retinal detachments, and other vision threatening conditions. These digital images are stored in the computer and can be used to help better evaluate the optic nerve, macula, and blood vessels of the retina on a year to year basis. This allows the doctor to observe even the smallest change from the previous exams.
The retinal photo is strongly recommended if any of the following apply:

1. If you are a new patient to this office.
2. If you have never had retinal photos in this office.
3. If you are 65 or older.
4. If you have or have a family history of high cholesterol, elevated blood pressure or any circulatory disorder.
5. If you have or have a family history of diabetes or elevated blood sugar.
6. If you have headaches or visual disturbances suggestive of a neurological problem.
7. If you have or have a family history of elevated eye pressure or glaucoma.
8. If you have any retinal disorder such as a detachment, tear, floaters, veils, flashing lights, bleeding, or macular degeneration.
9. If your vision is not correctable to 20/20 in one or both eyes.
10. If you were told by your previous eye doctor of some changes in the back of your eyes.

Retinal photos are a recommended part of your eye exam if you fall into any of the above categories and does not replace the dilation. ***The charge for this procedure is $30.00.***

Please check one: _____ **YES**, I want this procedure _____ **NO**, I do not want this procedure

_____________ By initialing, I acknowledge that I have read and understand the retinal photo consent.

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For Office Use Only

I, the patient listed above or their guardian, confirm with my signature that upon completion of the Contact Lens Fitting and any follow ups required, I received a copy of my contact lens prescription.

Patient Name: ____ Date: ___________________________